U.S. Department of Labor

Office of Administrative Law Judges
800 K Street, NW, Suite 400-N
Washington, DC 20001-8002

(202) 693-7300
(202) 693-7365 (FAX)

Issue Date: 12 March 2007*In the Matter of*

W. S.,
Claimant
v.
PATSY JANE COAL CORP.,
Employer

Case No. 2004-BLA-5180

and

LIBERTY MUTUAL INSURANCE COMPANY,
Carrier

and
DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-Interest

Appearances:

James D. Holliday, Esquire
For the Claimant

Francesca Maggard, Esquire
For the Employer

Before: Daniel F. Solomon
Administrative Law Judge

DECISION AND ORDER – AWARDING BENEFITS

This case arises from a claim for benefits under the "Black Lung Benefits Act," Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. §901 et seq. (hereinafter referred to as "the Act"), and applicable federal regulations, mainly 20 C.F.R. Parts 410, 718 and 727 ("Regulations").

Benefits under the Act are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis or to the survivors of persons whose death was

caused by pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as black lung.[1]

A formal hearing was conducted in Hazard, Kentucky on November 1, 2005 at which all parties were afforded a full opportunity to present evidence and argument, as provided in the Act and Regulations issued thereunder, found in Title 20, Code of Federal Regulations.[2]

ISSUES

The contested issues are:

1. Whether the claim was timely filed;
2. Whether Claimant has established a material change of condition pursuant to §725.309;
3. Whether Claimant has pneumoconiosis;
4. Whether Claimant's pneumoconiosis was caused by his coal mine employment;
5. Whether Claimant has a totally disabling respiratory impairment; and
6. Whether the total disability was due to pneumoconiosis. TR 7; DX 34.

STIPULATIONS

Pursuant to 20 CFR § 725.461(a), which sets forth in pertinent part, "…stipulations shall be considered the evidence of record in the case and the decision shall be based upon such evidence," the parties have agreed to the following:

1. The parties stipulated and I find that Claimant was a coal miner, within the meaning of the Act, for 15 years. TR 8.

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[1] The following abbreviations have been used in this opinion: DX = Director's exhibit, EX = Employer's exhibit, CX = Claimant's exhibit, TR = Transcript of the hearing, BCR = Board-certified radiologist, BCI = Board-certified internist, and B = B reader.

[2] At the hearing, Director's exhibits 1 through 36, Claimant's exhibits 1 through 6, and Employer's exhibits 1 through 3 were admitted into evidence for purposes of identification. TR 7, 10, 23. At the close of the hearing, the parties were asked to designate their evidence in conformance with the regulations. That evidence will be summarized in this opinion. In addition, there were a few evidentiary matters that were to be briefed by the parties in the closing briefs. That evidence (marked with asterisks) will also be summarized followed by a discussion of each item's admissibility. Employer filed its closing brief on February 28, 2006 and Claimant filed his closing brief on March 7, 2006.

In addition, the case file contains a supplemental medical report from Dr. Baker dated December 21, 2004. This report had been forwarded to the Office of Administrative Law Judges from the Director's office on January 18, 2005. Counsel for the Director requested that this document be associated with the file. This document is hereby marked Director's exhibit 37 and is hereby admitted into evidence. Also, the 1-30-03 medical report of Dr. Batra was forwarded by the Director's office on February 4, 2005. The Director requested that the report be marked Director's exhibit 38. However, this report is already in evidence as Claimant's exhibit 5. To avoid unnecessary duplicity, I will not mark the report as a Director's exhibit as requested by the Director. Instead it will be retained in the file as a duplicate report.

2. The parties stipulated and I find the evidence of record supports the conclusion that Patsy Jane Coal Company is the properly named responsible operator in this case. DX 34.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Procedural History and Factual Background[3]

Claimant filed his first claim for benefits on April 5, 1988. DX 1. The claim was denied by the claims examiner on September 15, 1988. Claimant failed to establish the presence of pneumoconiosis and a totally disabling respiratory impairment. No further action was taken on the claim.

Claimant filed his second claim for benefits on March 6, 2002. DX 3. The claims examiner issued a Proposed Decision and Order Awarding Benefits on June 26, 2003. DX 24. Employer disagreed and requested a formal hearing. The file was subsequently transferred to the Office of Administrative Law Judges on October 29, 2003. DX 34.

At the hearing, Claimant testified that he last worked in September of 1995. TR 12. He stated that he ran a cutting machine which was the same job that the continuous miner does now. TR 13. As part of his job he would have to lift 50 pound bags of rock dust. TR 13-14. He would also have to shovel coal weighing 20 pounds. TR 14. He stated that he treated with a nurse practitioner every three months. He has an inhaler for his breathing. TR 16. Claimant stated that he worked in surface mining running a dozer. TR 16. He also had to lift heavy parts in order to repair the dozer. TR 16. Claimant testified that he was short of breath and was able to do much lifting, walking, or carrying. TR 17. He opined he could not go back to running a cutting machine. TR 17. He stated that prior to his examination with Dr. Baker no doctor had told him he was totally and permanently disabled due to black lung disease.[4] TR 17.

On cross-examination, Claimant stated that he smoked one pack of cigarettes per day for about 50 years and continuing. TR 18. He noted that he spent about 10-11 years underground and spent the majority of his time in surface mines. He stated that his wife's name was Lenore. TR 19. Claimant noted that he had a low back injury that caused him to leave the mines. TR 20. He stated that he did not really know Dr. Batra and that he was never hospitalized for his breathing. TR 21.

Medical Evidence

The following is a summary of the medical evidence submitted in conjunction with Claimant's most recent claim for benefits. The parties have designated this evidence in conformance with the medical evidence limitations promulgated under the amended regulations to the Act. In addition, at the hearing I deferred ruling on several documents that were offered as evidence at the hearing. The parties were requested to address these evidentiary issues in their

[3] Claimant's most recent coal mine employment was in Kentucky, therefore, the rulings of the U.S. Court of Appeals for the Sixth Circuit control this case. *See* ***Kopp v. Director, OWCP***, 877 F.2d 307 (4th Cir. 1989).

[4] Employer contested the issue of timeliness at the hearing. Employer did not address this issue in its closing brief and did not produce or point to any evidence challenging Claimant's testimony. Therefore, based on the credible testimony of Claimant, I find that Claimant timely filed his application for benefits under the Act.

closing briefs. This evidence will be summarized below and will be designated with an asterisk. A discussion of admissibility will then follow.

Chest X-rays

Exhibit Number	Date of X-ray	Physician/Qualifications	Diagnosis
DX 11	4-16-02	Baker/ B	1/0
DX 16	4-16-02	Wheeler/ BCR, B	0/0
CX 1	4-16-02	Alexander/ BCR, B	1/0
DX 13	10-29-02	Dahhan/ B	0/0
DX 15*	10-29-02	Wheeler/ BCR, B	0/0
CX 2	10-29-02	Alexander/ BCR, B	1/0
DX 17	9-10-03	Broudy/ B	0/0
CX 3	9-10-03	Alexander/ BCR, B	1/0

In his closing brief, Claimant challenges the admission of Dr. Wheeler's interpretation of the 10-29-02 chest x-ray (DX 15). At the hearing, Employer designated this reading as rehabilitative evidence. Claimant argues that pursuant to §725.414(a)(3)(ii), the responsible operator can only obtain an additional statement from the physician who originally interpreted the chest x-ray. In this case that would be from Dr. Dahhan.

Rehabilitative evidence is permitted only if the opposing party has presented a reading which "tends to undermine" a specific x-ray exhibit set forth as initial evidence. In such a case, the proponent of the x-ray exhibit "shall be entitled to submit an additional statement from the physician who originally interpreted the chest x-ray." 20 C.F.R. §725.414(a)(2)(ii) and (3)(ii)(2001).

In the instant matter, Employer designated the 10-29-02 negative (0/0) x-ray reading of Dr. Dahhan as its initial evidence. Claimant submitted the positive (1/0) x-ray reading of Dr. Alexander as rebuttal. Under the regulations, since Claimant's rebuttal tends to undermine Dr. Dahhan's negative reading, Employer would be entitled to submit an additional statement from Dr. Dahhan. However, Employer is not entitled to submit an additional reading from another, and in this case more qualified, physician. For this reason, although the 10-29-02 chest x-ray reading by Dr. Wheeler is admitted into evidence, it is not included in my discussion of this issue.

Pulmonary Function Studies[5]

Exhibit	Date	Age	Height	FEV 1	MVV	FVC	Qualify
DX 11	4-16-02	65	65"	1.30	----	2.86	No
DX 13	10-29-02	65	165 cm 65"	1.42 ^1.55	44 ^40	2.44 ^2.81	Yes Yes
DX 17	9-10-03	66	66"	1.08 ^1.08	28 ^31	1.96 ^2.03	Yes Yes

^post-bronchodilator

[5] Due to the discrepancy in height, qualification of the vent studies is based on an average height of 65.6 inches. This average takes into account the two earlier pulmonary function studies from 1988.

Arterial Blood Gas Studies

Exhibit	Date	PO2	PCO2	Qualify
DX 11	4-16-02	68	44	No
DX 13	10-29-02	79.6	40.7	No
DX 17	9-10-03	75.5	41.8	No

Medical Reports

Dr. Glen Baker

The medical report of Dr. Baker is dated April 16, 2002 and appears at DX 11. Dr. Baker conducted his examination at the request of the Department of Labor. He reviewed Claimant's occupational history and noted a family medical history of cancer and allergies. Claimant had a positive medical history for pleurisy, attacks of wheezing, chronic bronchitis, arthritis, and high blood pressure. Claimant reported a smoking history of one pack of cigarettes per day for 35 to 40 years and continuing. Claimant's chief complaints were cough with sputum production, wheezing, dyspnea, orthopnea, and ankle edema. Physical examination of the lungs revealed scattered inspiratory/expiratory wheezing. A chest x-ray was read as 1/0, a vent study showed moderate obstructive impairment, arterial blood gases showed mild-moderate resting arterial hypoxemia, and an EKG showed normal sinus rhythm.

Dr. Baker diagnosed Claimant as having: (1) coal worker's pneumoconiosis due to coal mine dust exposure based on abnormal chest x-ray and coal dust exposure, (2) chronic bronchitis due to coal mine dust exposure and cigarette smoking based on a history of cough, sputum production, and wheezing, (3) COPD due to coal mine dust exposure and cigarette smoking based on pulmonary function studies, and (5) hypoxemia due to coal mine dust exposure and cigarette smoking based on PO2 level. Dr. Baker opined Claimant had a moderate impairment with decreased FEV-1, decreased PO2, chronic bronchitis, and CWP. He concluded that the foregoing diagnoses contributed "fully" to this impairment. He noted that the pulmonary impairment was caused by cigarette smoking and coal mine dust exposure and that Claimant did not maintain the capacity to perform his last coal mine employment based on the FEV-1 of 50%.

The supplemental report of Dr. Baker is dated December 21, 2004 and appears at DX 37. According to his letter-head, Dr. Baker is Board-Certified in Internal Medicine and Pulmonary Disease and is a B-reader of chest x-rays. He noted that he reviewed Claimant's chart and noted a coal mine employment history of 26 years with 10 years in underground mining. He added Claimant had a 34 to 40 pack year smoking history. After reviewing his diagnostic testing, Dr. Baker stated Claimant had clinical pneumoconiosis based on chest x-ray and the absence of other conditions to cause x-ray changes. He added that Claimant had legal pneumoconiosis with moderate obstructive vent impairment, a symptom complex of chronic bronchitis for 8 to 10 years, and mild to moderate resting arterial hypoxemia. He noted Claimant would have a class 3 pulmonary impairment and would be unable to perform the work of coal miner.

The second supplemental report *of Dr. Baker is dated September 22, 2005 and appears at CX 6. [6] He reviewed the medical reports of Drs. Broudy and Dahhan and agreed that both

[6] Claimant offered this report as rehabilitative evidence noting that Employer submitted rebuttal evidence (EX 2; EX 3) challenging the findings of Drs. Baker, Alam, and Batra. In its closing brief, Employer argues this report was submitted as rebuttal to the opinions of Drs. Dahhan and Broudy and that Claimant had already had these reports rebutted by Dr. Alam. Employer argues

were well-trained pulmonary physicians. He noted that he disagreed with Dr. Broudy regarding the presence of pneumoconiosis and the harmful effect of coal dust on a susceptible individual. He reviewed the 2-26-04 letter from Dr. Dahhan and stated that he agreed that Claimant had COPD but disagreed that it was not related in any way to coal mine dust exposure. He agreed that there was 7-9 cc of loss per year due to coal dust exposure but noted that there was a similar reduction in cigarette smokers and that these were averages. He opined that the studies point to the fact that both cigarette smoking and coal dust exposure caused an equal amount of airways disease on the average person. He added that while Dr Dahhan says that this would only be the amount that would be expected for a coal miner, it is also the amount that would be expected for a cigarette smoker. He opined that the greater than normal reduction in the FEV-1 was due to a combination of cigarette smoking and coal dust in unclear percentage. He stated that it was difficult to partition the effects of each on causation but felt that it was fairly close to equal. Dr. Baker, however, noted that because of Claimant's long cigarette smoking history compared to coal mining exposure, cigarette smoking may be the predominate cause but felt that coal mine dust was significant as well. He stated his belief that some people's lungs were more susceptible to lung damage from cigarette smoke, coal dust exposure, and air pollution. He added that these were common causes of COPD. He asked, "When one has two exposures that can cause obstructive airways disease, how can one intellectually dismiss one as being the cause and not the other as contributing to some extent? I, myself, feel they are somewhat susceptible to the harmful effects of cigarette smoke or coal dust; then he would probably be susceptible to both."

Dr. A. Dahhan

The medical report of Dr. Dahhan is dated November 5, 2002 and appears at DX 13. Dr. Dahhan is Board-Certified in Internal Medicine and Pulmonary Disease and is a B-reader. He examined Claimant at the request of Employer. He noted an occupational history of 25 years of coal mine employment ending in 1995 due to a back injury. Claimant stated that he smoked one pack of cigarettes per day since the age of 18 or a 47 pack year history. Claimant's chief complaints were daily cough with sputum and intermittent wheezing. Claimant had a history of hypertension. Physical examination of the chest revealed increased AP diameter with hyper resonance with percussion. Ascultation revealed scattered respiratory wheezes with no crepitation. An EKG and arterial blood gases were normal. Spirometry showed and FEV-1 of 46% of predicted and a chest x-ray was read as 0/0.

Based on the foregoing, Dr. Dahhan concluded Claimant had insufficient objective findings to justify the diagnosis of pneumoconiosis based on normal arterial blood gases, negative chest x-ray, and a significantly reversible obstructive vent defect on spirometry. He added that Claimant had chronic obstructive lung disease (COPD) and that he did not retain the physiologic capacity to continue his last coal mine work due to COPD. He opined that the

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therefore this report is inadmissible. I disagree. Claimant designated this report as rehabilitative evidence not rebuttal. Claimant designated the reports of Drs. Alam and Batra as his initial evidence. Dr. Baker, whose opinion supports an award of benefits, provided the OWCP evaluation in this case. Employer submitted the supplemental reports of Drs. Dahhan and Broudy to rebut the findings of Drs. Alam, Batra, and Baker. I find that Claimant appropriately has submitted a rehabilitative report by Dr. Baker responding to the arguments set forth by Drs. Dahhan and Broudy in their rebuttal reports.

COPD was due to his lengthy smoking history that Claimant continued to indulge in as confirmed by the elevated carboxyhemoglobin level. Dr. Dahhan concluded that Claimant's COPD was not caused by, related to, contributed to or aggravated by the inhalation of coal mine dust. He noted that Claimant has had no exposure to coal mine dust since 1995 and that enough time has passed to cause cessation of any industrial bronchitis Claimant may have had. Moreover, he added that the obstructive airways disease demonstrated a significant response to bronchodilator therapy, a finding that is inconsistent with the permanent adverse affects of coal dust on the respiratory system. Dr. Dahhan noted there was no evidence of complicated pneumoconiosis in this case.

The deposition* of Dr. Dahhan was taken on November 27, 2002 and appears at DX 14.[7] Dr. Dahhan diagnosed Claimant as having chronic bronchitis and emphysema due to smoking. He ruled out coal mine dust as a factor because (1) Claimant had no evidence of industrial bronchitis, (2) the obstructive defect due to coal mine dust was fixed and did not respond to bronchodilators, and (3) Claimant showed improvement with bronchodilators. He added that it could not be a combination of factors (smoking plus coal mine dust exposure) because of the foregoing reasons.

The supplemental report of Dr. Dahhan is dated February 26, 2004 and appears at EX 2. Employer offered this report as rebuttal evidence. Dr. Dahhan reviewed Dr. Batra's medical report and the diagnostic testing from Dr. Baker's examination. All of these items are in evidence in this matter. He stated that Claimant demonstrated a significant response to bronchodilator therapy as demonstrated by the FVC rising from 63% of predicted to 73% of predicted and FEV-1 from 46% to 51% of predicted. These findings indicated that the airway obstruction was not fixed as would be expected if it was due to the inhalation of coal mine dust. He stated that Claimant's loss in FEV-1 due to coal mine dust would be 7-9 cc per year for a total of 150 cc in this case. Claimant had a 1.53 liter reduction in FEV-1, an amount that far exceeded what would be expected if that reduction and secondary disability was due to the inhalation of coal mine dust. Dr. Dahhan concluded Claimant did not have CWP, either by legal or medical definition.

Dr. Bruce C. Broudy

The medical report of Dr. Broudy is dated September 10, 2003 and appears at DX 17. Dr. Broudy is Board-Certified in Internal Medicine and Pulmonary Disease and is a B-reader of chest x-rays. He examined Claimant at the request of Employer. He noted a smoking history of

[7] At the hearing, I questioned the admissibility of the deposition testimony of Drs. Dahhan and Broudy pursuant to the limitations on evidence imposed by the amended regulations. A ruling on admissibility was deferred on these items at the hearing. The parties were instead instructed to brief this issue in their closing briefs. However, neither party addressed this issue. Section §725.414(c) provides that a physician who prepared a medical report admitted under this section may testify with respect to the claim at any formal hearing or by deposition. Employer designated the medical reports of Drs. Dahhan and Broudy as their initial evidence and are entitled to submit deposition testimony from each pursuant to §725.414. In addition, I find that the testimony of Drs. Dahhan and Broudy was confined to the evidence in the record and was basically a reiteration of opinions and conclusions contained within their respective medical reports. Accordingly, I find that the deposition testimony of Drs. Dahhan and Broudy is admissible in this case.

one pack of cigarettes per day from a teenager on to the present. He reviewed Claimant's occupational history. Dr. Broudy noted that Claimant had been given inhalers for breathing but that it did not improve Claimant's breathing. Claimant complained of dyspnea on exertion going up a few stairs. In addition, Claimant had daily cough with sputum production. Physical examination of the chest revealed hyperresonance to percussion, lungs were noted to have diminished aeration, and there was severe respiratory delay with rhonchi on forced expiration. Spirometry showed severe obstructive airways disease with no responsiveness to bronchodilators. The arterial blood gases were normal and the chest x-ray was negative for pneumoconiosis. Dr. Broudy diagnosed Claimant as having very severe chronic obstructive airways disease due to cigarette smoking. He concluded there was no evidence Claimant had CWP or any chronic lung disease caused by the inhalation of coal mine dust. He added that due to the severe COPD due to smoking, Claimant did not retain the respiratory capacity to perform the work of an underground coal miner.

The deposition* of Dr. Broudy was taken on February 23, 2004 and appears at EX 1.[8] Dr. Broudy stated that in order to determine whether coal mine dust was associated with COPD he would look to the chest x-rays for evidence of progressive massive fibrosis. If none was present it would be very unlikely there would be any significant obstructive airways disease associated with the inhalation of coal mine dust. He acknowledged that coal mine dust could cause some impairment in lung function and estimated that 5% of Claimant's FEV-1 loss could be due to coal mine dust. He noted that this was a very slight decrease. He agreed that coal dust could aggravate bronchitis, asthma, and COPD. He noted that Claimant's pulmonary function worsened since 1998 and the fact that Claimant continued to smoke during this period made it far more likely that the smoking was the cause of the further impairment. He added that Claimant's chest x-ray had not changed over the same time frame. Dr. Broudy agreed that when an individual stopped working in the mines, any irritation caused by coal dust would also go away. He noted that it would be difficult to diagnose clinical pneumoconiosis without chest x-ray evidence, significant lung impairment, or lung biopsy showing pneumoconiosis.

The supplemental report of Dr. Broudy is dated February 13, 2005 and appears at EX 3. Employer offered this report as rebuttal evidence. He reviewed the medical reports of Drs. Baker and Alam as well as the chest x-ray re-reading by Dr. Alexander. Because it exceeds the limitations on evidence, I will not consider Dr. Broudy's comments on the chest x-ray. He stated that he disagreed with Dr. Baker's opinion that Claimant's impairment was due to both coal mine dust and smoking. He believed that all of the impairment was due to pulmonary emphysema and COPD which have resulted from Claimant's lifelong smoking habit. He likewise disagreed with the conclusions of Dr. Alam that CWP contributed to Claimant's impairment in any significant way.

Dr. C.P. Batra

The medical report of Dr. Batra is dated January 30, 2003 and appears at CX 5. The qualifications of Dr. Batra are not in the record. He noted that based on his examination, Claimant had an occupational lung disease caused by coal mine employment. He based this diagnosis on productive cough, wheezing, and exertional dyspnea. He opined Claimant had both legal and clinical pneumoconiosis. Dr. Batra concluded Claimant had a moderate impairment due to pneumoconiosis and that he did not have the respiratory capacity to perform the work of a

[8] See the previous footnote for discussion of the admissibility of Dr. Broudy's deposition.

coal miner. This conclusion was based on Claimant's shortness of breath on exertion, hypoxemia, and moderate obstructive pulmonary disease. He opined that Claimant's employment history had an adverse affect on his cardiopulmonary status.

Dr. Mahmood Alam

The medical report of Dr. Alam is dated December 16, 2004 and appears at CX 4. Dr. Alam is Board-Certified in Internal Medicine and Pulmonary Disease. He conducted a medical record review at the request of Claimant.[9] He noted, assuming a minimum of 15 years of coal mine employment, Claimant had significant exposure to coal dust to develop pneumoconiosis. He noted that all of the physicians agreed that Claimant's FEV-1 showed severe airflow obstruction and that he did not retain the physiologic capacity to perform his coal mine job. He added that all of the physicians agreed that Claimant had emphysema based on chest x-ray and noted that in cases of severe emphysema, nodules may not be apparent on plain chest x-ray films. He diagnosed Claimant as having both legal and clinical pneumoconiosis. Dr. Alam stated that Claimant's FEV-1 declined from 1986 to 2003 and during that time worked nine years in the coal mine (meaning from 1986 to 1995) while continuing to smoke. He opined that some of the decline had to be from coal mine dust. Dr. Alam stated that coal mine dust as well as tobacco abuse were responsible for Claimant's emphysema. He concluded that CWP and persistent tobacco abuse could be a progressive problem and disease manifesting in declining FEV-1, abnormality on chest x-rays, and abnormal gas exchange. He added that this had to be a combined etiology including coal mine dust. Dr. Alam opined that not giving etiological weight to coal dust was not reasonable.

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[9] Of significance to the parties is the fact that Dr. Alam mentioned a pulmonary function study from August of 1986 that purportedly is not in the record. Claimant argues in his brief that it was a typographical error and that it should have been listed as 1988. Conversely, Employer argues that since Dr. Alam's report was based on evidence not contained within the formal file, it could not be considered as evidence of legal pneumoconiosis. I disagree.

As Claimant noted in his brief, in ***Harris v. Old Ben Coal Company***, 23 B.L.R. 1-__, BRB No. 04-0812 BLA (Jan. 27, 2006) (en banc), the Board noted that when an Administrative Law Judge is confronted with an opinion that considers evidence not admitted into the formal record, he then may exclude the report, redact the objectionable content, ask the physicians to submit revised reports, or consider the physician's reliance on inadmissible evidence in deciding the probative value to accord their opinions. The Board added that the Administrative Law Judge "appropriately indicated that exclusion is not a favored option, as it would result in the loss of probative evidence developed in compliance with evidentiary limitations."

As noted, Claimant argued there likely was a typographical error in Dr. Alam's report and that said pulmonary function study was probably from 1988. I find that although there are two vent studies in the record (Claimant's first application for benefits, see infra, DX 1) from 1988, neither are from August making it unlikely this was a typographical error. However, pursuant to the Board's holding in ***Harris, supra*** I will consider Dr. Alam's reliance on the inadmissible vent study in deciding the probative value to accord his opinion in the discussion portion of this decision.

CONCLUSIONS OF LAW

Burden of Proof

"Burden of proof," as used in this setting and under the Administrative Procedure Act[10] is that "[e]xcept as otherwise provided by statute, the proponent of a rule or order has the burden of proof". "Burden of proof" means burden of persuasion, not merely burden of production. 5 U.S.C.A. § 556(d).[11] The drafters of the APA used the term "burden of proof" to mean the burden of persuasion. ***Director, OWCP, Department of Labor v. Greenwich Collieries*** [Ondecko], 512 U.S. 267, 114 S.Ct. 2251 (1994).[12]

A claimant has the general burden of establishing entitlement *and* the initial burden of going forward with the evidence. The obligation is to persuade the trier of fact of the truth of a proposition, not simply the burden of production, the obligation to come forward with evidence to support a claim.[13] Therefore, the claimant cannot rely on the Director to gather evidence.[14] A claimant, bears the risk of non-persuasion if the evidence is found insufficient to establish a crucial element. ***Oggero v. Director, OWCP***, 7 BLR 1-860 (1985).

The amended regulations make clear that the applicable conditions of entitlement shall be limited to those conditions upon which the prior denial was based. § 725.309(d)(2). In the denial of the miner's first claim, it was found that Claimant failed to establish the existence of pneumoconiosis and the presence of a totally disabling pulmonary impairment.

Subsequent Claims

Any time within one year of a denial or award of benefits, any party to the proceeding may request a reconsideration based on a change in condition or a mistake of fact made during the determination of the claim; see 20 C.F.R. §725.310. However, after the expiration of one year, the submission of additional material or another claim is considered a subsequent claim which will be denied on the basis of the prior denial unless the claimant demonstrates that one of the applicable conditions of entitlement has changes since the date upon which the order denying the prior claim became final. § 725.309(d) (2001). Under this regulatory provision, according to the Court of Appeals for the Sixth Circuit in ***Sharondale Corp. v. Ross***, 42 F.3d 993, 997-998 (6th Circuit 1994):

> [T]o assess whether a material change is established, the ALJ must consider all of the new evidence, favorable and unfavorable, and

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[10] 33 U.S.C. § 919(d) ("[N]otwithstanding any other provisions of this chapter, any hearing held under this chapter shall be conducted in accordance with [the APA]"); 5 U.S.C. § 554(c)(2). Longshore and Harbor Workers' Compensation Act ("LHWCA"), 33 U.S.C. §§ 901-950, is incorporated by reference into Part C of the Black Lung Act pursuant to 30 U.S.C. §§ 932(a).

[11] The Tenth and Eleventh Circuits held that the burden of persuasion is greater than the burden of production, ***Alabama By-Products Corp. v. Killingsworth***, 733 F.2d 1511, 6 BLR 2-59 (11th Cir. 1984); ***Kaiser Steel Corp. v. Director, OWCP*** [*Sainz*], 748 F.2d 1426, 7 BLR 2-84 (10th Cir. 1984). These cases arose in the context where an interim presumption is triggered, and the burden of proof shifted from a claimant to an employer/carrier.

[12] Also known as the risk of nonpersuasion, see 9 J. Wigmore, ***Evidence*** § 2486 (J. Chadbourn rev.1981).

[13] ***Id****, also see* ***White v. Director, OWCP***, 6 BLR 1-368 (1983)

[14] ***Id***.

> determine whether the miner has proven at least one of the elements of entitlement previously adjudicated against him. If the miner establishes the existence of that element, he has demonstrated, as a matter of law, a material change. Then, the ALJ must consider whether all of the record evidence, including that submitted with the previous claims, supports a finding of entitlement to benefits.

I interpret the *Sharondale* approach to mean that the relevant inquiry in a subsequent claim is whether evidence developed since the prior adjudication would now support a finding of an element of entitlement. The court in ***Peabody Coal Company v. Spese***, 117 F.3d 1001, 1008 (7th Circuit 1997) put the concept in clearer terms:

> The key point is that the claimant cannot simply bring in new evidence that addresses his condition at the time of the earlier denial. His theory of recovery on the new claim must be consistent with the assumption that the original denial was correct. To prevail on the new claim, therefore, the miner must show that something capable of making a difference has changed since the record closed on the first application.

In the instant case, Claimant was unable to establish any element of entitlement in his first claim for benefits. DX 1. I find that the newly submitted medical opinions are unanimous that Claimant now suffers from a totally disabling pulmonary impairment. DX 11; DX 13; DX 17; CX 4; CX 5. There is no contrary evidence in the record and Employer appears to have conceded this issue in its closing brief. Because Claimant has established one of the elements of entitlement previously denied, he has established a material change in conditions and is entitled to a *de novo* review of the evidence.

Evidence From Claimant's First Application for Benefits

Chest X-rays

Exhibit Number	Date of X-ray	Physician/Qualifications	Diagnosis
DX 1	9-29-75	Williams/ B	Negative for CWP
DX 1	4-29-88	Williams/ B	Normal chest
DX 1	4-29-88	Poulos/ BCR, B	Negative
DX 1	4-29-88	Sargent/ BCR, B	Negative for CWP
DX 1	12-1-88	Broudy/ B	0/0
DX 1	12-1-88	Manning/ BCR, B	Negative

Pulmonary Function Tests

Exhibit	Date	Age	Height	FEV 1	MVV	FVC	Qualify
DX 1	4-29-88	50	66"	2.12	70.7	3.19	No
DX 1	12-1-88	51	66"	2.71	92	3.76	No

Arterial Blood Gases

Exhibit	Date	PO2	PCO2	Qualify
DX 1	4-29-88	80.1 ^97.2	38.4 ^34.7	No No
DX 1	8-6-88	71	36	No

DX 1	12-1-88	89.9	36.1	No

^Post-exercise

Medical Reports

Dr. Anderson

The medical report of Dr. Anderson is dated September 17, 1986 and appears at DX 1. At the time Claimant was 49 years old and reportedly smoked one pack of cigarettes per day from the age of 20. He concluded Claimant had no evidence of pneumoconiosis but did have signs of emphysema of the type seen in smokers.

Dr. Williams

The medical report of Dr. Williams is dated April 29, 1988 and appears at DX 1. After an examination, Dr. Williams concluded Claimant was a normal healthy male with no evidence of significant cardiopulmonary disease.

Dr. Broudy

The medical report of Dr. Broudy is dated December 1, 1988 and appears at DX 1. He noted a smoking history of 1 ½ packs per day for 30 years. He concluded Claimant had no evidence of pneumoconiosis and maintained the pulmonary capacity to perform his last coal mine employment. He opined Claimant's dyspnea was non-pulmonary in origin.

The deposition testimony of Dr. Broudy was basically a reiteration of his medical report. DX 1.

Entitlement: In General

To establish entitlement to benefits, a claimant must establish that he had pneumoconiosis, that his pneumoconiosis arose out of coal mine employment, that claimant was totally disabled, and that his total disability was due to pneumoconiosis.

As noted, Claimant has established a material change in conditions and is entitled to a *de novo* review of the evidence to determine whether he is entitled to benefits.

Determination of Pneumoconiosis

30 U.S.C. § 902(b) and 20 C.F.R. § 718.201 define pneumoconiosis as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." [15] The definition is not confined to "coal workers' pneumoconiosis," but also includes other diseases arising out of coal mine employment, such as anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or silicotuberculosis.[16] 20 C.F.R. § 718.201. The term "arising out of coal

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[15] Pneumoconiosis is a progressive and irreversible disease; once present, it does not go away. ***Mullins Coal Co. v. Director, OWCP,*** 484 U.S. 135, 151 (1987); ***Lisa Lee Mines v. Director***, 86 F.3d 1358 (4th Cir. 1996)(*en banc*) at 1364; ***LaBelle Processing Co. v. Swarrow***, 72 F.3d 308 (3d Cir. 1995) at 314-315.

[16] Regulatory amendments, effective January 19, 2001, state:

mine employment" is defined as including "any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment."

The claimant has the burden of proving the existence of pneumoconiosis by any one of four methods. The Regulations provide the means of establishing the existence of pneumoconiosis by: (1) a chest X-ray meeting the criteria set forth in 20 C.F.R. § 718.202(a); (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. § 718.106; (3) application of the irrefutable presumption for "complicated pneumoconiosis" found in 20 C.F.R. § 718.304; or (4) a determination of the existence of pneumoconiosis made by a physician exercising sound judgment, based upon certain clinical data and medical and work histories, and supported by a reasoned medical opinion. 20 C.F.R. § 718.202(a). Pulmonary function studies are not diagnostic of the presence or absence of pneumoconiosis. ***Burke v. Director, OWCP***, 3 B.L.R. 1-410 (1981).

Chest X-ray Evidence

A finding of the existence of pneumoconiosis may be made with positive chest x-ray evidence. 20 C.F.R. § 718.202(a)(1). The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest x-ray classified as category 0, including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). Where two or more x-ray reports are in conflict, the radiologic qualifications of the physicians interpreting the x-rays must be considered. §718.201(a)(1).

While a judge is not required to defer to the numerical superiority of x-ray evidence, although it is within his or her discretion to do so. ***Wilt v. Woverine Mining Co.***, 14 B.L.R. 1-70

(a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.

(1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure. (Emphasis added).

(1990) citing ***Edmiston v. F & R Coal,*** 14 B.L.R. 1-65 (1990). The ALJ must rely on the evidence which he deems to be most probative, even where it is contrary to the numerical majority. ***Tokarcik v. Consolidation Coal Co.***, 6 B.L.R. 1-666 (1984).

In summary, of the newly submitted evidence, there are eight(8) interpretations of three (3) x-rays that have been submitted as part of Claimant's current claim for benefits. The reading by Dr. Wheeler of the 10/ 29/02 x-ray is disputed, and I previously ruled that it is not rehabilitative evidence, however, even if it were used, the positive evidence is more numerous.

The Benefits Review Board has held that it is proper to credit the interpretation of a dually qualified physician over the interpretation of a B-reader. ***Cranor v. Peabody Coal Co.***, 22 B.L.R. 1-1 (1999). (en banc on recon.). There are five (5) interpretations by dually qualified Board-Certified Radiologists and B-readers in this case. Again, I do not use the Wheeler interpretation of the 10/ 29/02 x-ray, but even if I did, three (3) of the interpretations would be positive for pneumoconiosis and two (2) interpretations were negative for pneumoconiosis. Therefore of the better qualified readers, the most numerous readings are positive for the existence of pneumoconiosis.

Because pneumoconiosis is a progressive and irreversible disease, it may be appropriate to accord greater weight to the most recent evidence of record, especially where a significant amount of time separates newer evidence from that evidence which is older. ***Clark v. Karst-;Robbins Coal Co***., 12 B.L.R. 1-;149 (1989)(en banc); ***Casella v. Kaiser Steel Cor***p., 9 B.L.R. 1-131 (1986). I also note that the most recent x-ray, 9/10/03, readings were in conflict. However, I note that the most qualified of the two readers, Dr. Alexander, dually qualified read it as positive. I find that the most recent evidence is more probative.

Accordingly, since the majority of the more credible x-ray evidence is positive for the presence of pneumoconiosis, I find that Claimant has established, by the preponderance of the newly submitted evidence, the existence of pneumoconiosis pursuant to §718.202(a)(1).

In addition, there are six (6) readings of three (3) chest x-rays in evidence as part of Claimant's earlier claim for benefits. All six (6) readings were negative for pneumoconiosis. These x-rays are more than ten years old and are less probative of Claimant's current medical condition. I therefore accord these x-ray interpretations less weight.

I find that Claimant has established the existence of pneumoconiosis pursuant to §718.202(a)(1).

Biopsy Evidence

Pursuant to §718.202(a)(2) Claimant may establish pneumoconiosis through the use of biopsy evidence. Since no such evidence was submitted, it is clear that pneumoconiosis has not been established in this manner.

The Presumptions

Under §718.202(a)(3) it shall be presumed that a miner is suffering from pneumoconiosis if the presumptions provided in §§718.304, 718.305, or 718.306 apply.

Initially, I note that Claimant cannot qualify for the §718.305 presumption because he did not file this claim before January 1, 1982. Claimant is also ineligible for the §718.306 presumption because he is still living.

The third presumption involves the existence of complicated pneumoconiosis. §718.304. Complicated pneumoconiosis is established by x-rays classified as Category A, B, C, or by an autopsy or biopsy that yields evidence of massive lesions in the lung.

There are no chest x-ray readings positive for complicated pneumoconiosis. Accordingly, based on the chest x-ray evidence, Claimant has failed to establish, by the preponderance of the evidence, the existence of complicated pneumoconiosis.

Medical Opinions

Lastly, under §718.202(a)(4) a finding of pneumoconiosis may be based on the opinion of a physician, exercising sound medical judgment, who concludes that the miner suffers or suffered from pneumoconiosis. Such conclusion must be based on objective medical evidence and must be supported by a reasoned medical opinion.

Smoking History

In general, in order for physicians to arrive at a proper, reasoned diagnosis, it is essential that they be presented with an accurate picture of a patient's complaints, prior medical history, working or environmental conditions, and social habits, including smoking. ***See Stark v. Director, OWCP***, 9 B.L.R. 1-36 (1986) (An opinion may be given less weight where the physician did not have a complete picture of the miner's condition.).

Specifically, in Black Lung cases, a claimant's smoking history is of particular importance. This is because the pulmonary manifestations of smoking are often similar to that of coal workers' pneumoconiosis.

I find that Claimant consistently reported a smoking history of about 1 pack of cigarettes per day for about 50 years and continuing. TR 18.

Analysis of Medical Opinions

There are five (5) physicians that have rendered an opinion in this matter. In general, Drs. Baker, Batra, and Alam diagnosed the presence of clinical and legal pneumoconiosis. Conversely, Drs. Broudy and Dahhan found there was insufficient evidence to diagnose pneumoconiosis.

I first note that Drs. Baker, Alam, Dahhan, and Broudy are highly qualified physicians who have excellent credentials. All four are Board-Certified in Internal Medicine and Pulmonary Disease. Accordingly, I find Drs. Baker, Alam, Dahhan, and Broudy to be highly qualified to render an opinion in this matter. ***Burns v. Director, OWCP***, 7 B.L.R. 1-597 (1984). Conversely, the qualifications of Dr. Batra are unknown.

In his closing brief, Claimant noted that Dr. Batra was his treating physician. In weighing the medical evidence of record, the adjudication officer must give consideration to the relationship between the miner and any treating physician whose report is admitted into evidence. Factors to consider include the nature of the relationship, duration of the relationship, frequency of treatment, and extent of treatment. §718.104(d). In appropriate cases, the relationship between the miner and his treating physician may constitute substantial evidence in support of the adjudication officer's decision to give that physician's opinion controlling weight, provided that the weight given to the opinion of a miner's treating physician shall also be based on the credibility of the physician's opinion in light of its reasoning and documentation, other relevant evidence and the record as a whole. §718.104(d)(5).

I find that there is no evidence in the record that Dr. Batra was Claimant's treating physician. In fact, to the contrary, Claimant testified at the hearing that he really did not know Dr. Batra. TR 21. Based on the foregoing, I find that the opinion of Dr. Batra is not entitled to any special consideration pursuant to the "treating physician" rule. Moreover, I find that the opinion of Dr. Batra is not well-reasoned and is not well-documented and is entitled to less weight. He opined Claimant had legal and clinical pneumoconiosis. He apparently based his opinion solely on Claimant's subjective complaints of productive cough, wheezing, and exertional dyspnea. It is not known if Dr. Batra examined Claimant in person, what, if any, objective diagnostic testing was performed, whether he looked at a chest x-ray, or had any understanding of Claimant's occupational history. Of significance, Dr. Batra failed to mention Claimant's substantial smoking history and what affects it may have on Claimant's respiratory system. For all we know, Dr. Batra may not have even been aware of Claimant's smoking. Based on the foregoing, I find the opinion of Dr. Batra is entitled to less weight.

Conversely, I accord great weight to the opinion of Dr. Baker. I find that his opinion is well-reasoned and well-documented and is consistent with the more credible chest x-ray evidence that was positive for pneumoconiosis, Claimant's severe obstructive defect on pulmonary function studies, his occupational history, smoking history, subjective complaints, and medical history. He diagnosed the presence of legal pneumoconiosis noting that Claimant's chronic bronchitis and COPD were due both to coal mine dust and cigarette smoking. He persuasively explained in his supplemental report that, on average, a person could experience an FEV-1 loss of 7-9 cc per year due to coal mine dust while having a similar reduction due to cigarette smoking. Claimant in this case suffered from a far greater loss in FEV-1 than would be expected from both exposures combined. He explained his belief that some people were just more susceptible to sustain lung damage due to these factors and if one was susceptible to the effects of one factor then he should be susceptible to the other. Dr. Baker first opined that each factor contributed equally to the loss in FEV-1. However, after re-considering Claimant's substantial, heavy smoking history he opined that cigarette smoking could be the predominating cause but that coal mine dust was a significant contributor as well. I find the foregoing argument to be highly persuasive, reasonable, and credible.

Employer argued in its brief that Dr. Baker noted an occupational history of 26 years of coal mine employment and that was in excess of the 15 years stipulated to at the hearing. Employer stated that because Dr. Baker had an over-inflated occupational history his opinion is not credible. I disagree. Dr. Baker did note a history of 26 years of coal mine employment but, of significance, noted that only 10 years were underground. This history, of 10 years of underground coal mine employment, is on point with Claimant's testimony at the hearing. Although Dr. Baker may have had an inflated coal mine history, the most significant exposure to coal dust would have certainly been in the underground coal mine. Because he had an otherwise accurate history of Claimant's underground coal mine dust exposure, I find this error benign.[17]

I find that Dr Baker's opinion is supported by the opinion of Dr. Alam. Dr. Alam noted Claimant had both legal and clinical pneumoconiosis. He noted that Claimant's decline in FEV-1 started while Claimant was still working in the mines and therefore reasoned that some of the

[17] I find it interesting to note that Employer's own consultant, Dr. Dahhan stated an occupational history of 25 years of coal mine employment in his original report.

decline had to be from coal mine dust.[18] He added that coal mine dust and smoking were responsible for Claimant's emphysema since both caused: (1) declining FEV-1s, (2) abnormalities on x-rays, and (3) abnormal gas exchange. I find the foregoing to be reasonable and persuasive and therefore the opinion of Dr. Alam is accorded greater weight.

I accord less weight to the opinion of Dr. Dahhan on this issue. I find that his opinion was not well-reasoned and not consistent with the objective evidence of record. In particular, Dr. Dahhan concluded, contrary to the findings of this opinion, that Claimant did not have radiographic evidence of pneumoconiosis (clinical pneumoconiosis). As noted previously, I found that the more credible x-ray evidence was positive for the presence of pneumoconiosis. I also accord less weight to Dr. Dahhan's opinion that Claimant suffered from chronic bronchitis and emphysema due solely to smoking. Dr. Dahhan stated that Claimant had no exposure to coal mine dust since 1995 and therefore enough time had passed to cause cessation of any industrial bronchitis (or legal pneumoconiosis). I disagree. The regulations specifically state that "pneumoconiosis" is recognized as a *latent and progressive disease* which may first become detectable only after the cessation of coal mine dust exposure. In addition, Dr. Dahhan stated that Claimant had a significant response to bronchodilators which would be inconsistent with the permanent adverse effects of coal mine dust on lung tissue. Indeed, Claimant seemed to have had a response to bronchodilators in the 10-29-02 pulmonary function study. However, in the more recent 9-10-03 study, there was no change in the FEV-1 and a very small improvement in the FVC after bronchodilators were administered. In fact, Dr. Broudy interpreted this study as showing no response to bronchodilators. Based on Dr. Dahhan's reasoning, this more recent study would be considered to be consistent with the permanent adverse affects of coal mine dust on the respiratory system thus undermining his original conclusion that coal mine was having no significant impact on Claimant's respiratory condition.

Finally, in his supplemental report, Dr. Dahhan admitted that Claimant had sustained a 7-9 cc per year loss in FEV-1 due to coal mine dust for a total loss of 150 cc. He noted that Claimant had sustained a 1.53 liter loss in FEV-1, an amount that far exceeded what would be expected if that reduction and secondary disability was due to inhalation of coal mine dust. A reasonable reading of his opinion leaves the reader to conclude that the vast remainder of the loss had to be due to smoking. However, as Dr. Baker pointed out, Claimant would also be expected to only loose 7-9 cc per year due to smoking and that these figures were averages. Clearly, Claimant has had a more dramatic loss of FEV-1 than can be explained by these averages. Only Dr. Baker had a reasonable explanation for the difference: *susceptibility of the individual*. I find highly credible Dr. Baker's explanation that some people react differently to exposure to cigarette smoke and coal mine dust and if they are sensitive to one factor it is reasonable to conclude they should be sensitive to the other. Based on this persuasive argument it is difficult to argue how one could completely exclude one factor in favor of another. Based on all of the foregoing, I accord less weight to the opinion of Dr. Dahhan.

Likewise I accord less weight to the opinion of Dr. Broudy. I find that his opinion is not well-reasoned and is not well-documented. His finding of no clinical pneumoconiosis is contrary to the more credible x-ray interpretations that were positive for pneumoconiosis. Like Dr.

[18] Dr. Alam noted the decline in FEV-1 from 1986. As discussed previously, the 1986 pulmonary function study is not in evidence and any discussion involving that study will not be considered. That being said, I find that Claimant's FEV-1 began to decline from 1988 (the first pulmonary function study in evidence), a full seven years before Claimant left the coal mines.

Dahhan, Dr. Broudy estimated that 5% of Claimant's FEV-1 loss could be due to coal mine dust and that the remainder had to be from smoking. Like Dr. Dahhan, Dr. Broudy failed to note that a similar reduction would be expected, on average, due to smoking. Again, I find highly credible Dr. Baker's explanation that some people react differently to exposure to cigarette smoke and coal mine dust and if they are sensitive to one factor it is reasonable to conclude they should be sensitive to the other. Based on this persuasive argument it is difficult to argue how one could completely exclude one factor in favor of another. Finally, Dr. Broudy stated that in order to determine whether COPD was related to coal dust he would look to the chest x-rays for evidence of progressive massive fibrosis. If none was present it would be very unlikely there would be any significant airways disease associated with the inhalation of coal mine dust. This would eliminate any possibility of legal pneumoconiosis as a potential cause. Legal pneumoconiosis exists where x-ray evidence is not dispositive. I find that this view is contrary to the spirit of the regulations that note that even in the presence of smoking, coal mine dust exposure was clearly associated with clinically significant airways obstruction and bronchitis. ***65 Fed. Reg. 79,940 (Dec. 20, 2000).*** In ***Richardson v. Director, OWCP***, 94 F.3d 164 (4th Cir. 1996), the court reiterated that "[c]linical pneumoconiosis is only a small subset of the compensable afflictions that fall within the definition of legal pneumoconiosis under the Act" and that "COPD, if it arises out of coal mine employment, clearly is encompassed within the legal definition of pneumoconiosis, even though it is a disease apart from clinical pneumoconiosis." Based on all of the foregoing, I accord less weight to the opinion of Dr. Broudy.

Accordingly, based on the foregoing, I find Claimant has established, by the preponderance of the evidence, the existence of pneumoconiosis pursuant to §718.202(a)(4).

Cause of Pneumoconiosis Pursuant to 718.203

Once it is determined that the miner suffers from pneumoconiosis, it must be determined whether the miner's pneumoconiosis arose, at least in part, out of coal mine employment. 20 C.F.R. 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten years or more in the coal mines, there shall be a rebuttable presumption that the pneumoconiosis arose out of such employment.

I find that Claimant, with 15 years of coal mine employment, would be entitled to the rebuttable presumption at §718.203.

I found earlier in this opinion that Claimant established the existence of clinical pneumoconiosis pursuant to §718.202(a)(1) and legal pneumoconiosis pursuant to §718.202(a)(4). Regarding the finding of clinical pneumoconiosis, I find that Employer has presented no credible evidence to rebut the presumption that it arose out of Claimant's coal mine employment. In fact none of Employer's consultants made a diagnosis of clinical pneumoconiosis.

Disability Causation

The final issue is whether Claimant has established disability causation at Section 718.204(c)(1).

Pursuant to §718.204(c)(1) a miner shall be considered totally disabled due to pneumoconiosis if pneumoconiosis…is a substantially contributing cause of the miner's totally disabling respiratory impairment. Pneumoconiosis is a "substantially contributing cause" of the miner's disability if it:

(i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or

(ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment.

All of the consultant physicians agreed that Claimant suffered from a totally disabling respiratory impairment due to COPD but disagreed as to its cause. Drs. Baker, Alam, and Batra opined Claimant's COPD was due, at least in part, to coal mine dust exposure. Drs. Broudy and Dahhan admitted that coal mine dust caused a very minimal decline in Claimant's FEV-1 but concluded that it was clinically insignificant.

I find most convincing, the opinion of Dr. Baker on this issue. He considered Claimant's smoking history and coal mine dust exposure and opined that while smoking was the predominating cause, coal mine dust was still a significant factor in the development of COPD. I again find his reasoning to be persuasive, credible, and convincing and find that this description satisfies the "substantial contributing cause" definition. Moreover, Dr. Baker's opinion is supported by the report of Dr. Alam who noted that Claimant's COPD was due to a combined etiology: coal mine dust and smoking.

Conversely, I accord less weight to the opinion of Dr. Batra who did not consider at all the effects of Claimant's substantial smoking history on his totally disabling respiratory condition. Likewise, I find that the opinions of Drs. Broudy and Dahhan are outweighed by the highly persuasive opinion of Dr. Baker. In addition, I find that these experts underestimated the contribution by coal mine dust by utilizing *averages* and by overstating the impact of cigarette smoking on Claimant respiratory system.

Accordingly, I find that Claimant has established total disability due to pneumoconiosis pursuant to §718.204(c)(1).

Conclusion

Because Claimant has established all elements of entitlement, I must conclude that he has established entitlement to benefits under the Act.

Date of Onset

In a case where evidence does not establish the month of onset, benefits shall be payable beginning with the month during which the claim was filed. 20 C.F.R. §725.303(d). In the instant matter, Claimant filed his claim on March 6, 2002. DX 3.

Attorney's Fees

No award of attorney's fees for services to the Claimant is made herein since no application has been received. Thirty days are hereby allowed to Claimant's counsel for the submission of such application. His attention is directed to 20 C.F.R. §§725.365 and 725.366 of the regulations. A service sheet showing that service has been made upon all parties, including the Claimant, must accompany the application. Parties have ten days following receipt of such application within which to file any objections. The Act prohibits the charging of a fee in the absence of an approved application.

ORDER

The claim of W.S. for black lung benefits under the Act is hereby **GRANTED**, and

It is hereby **ORDERED** that **PATSY JANE COAL COMPANY**, the Responsible Operator, shall pay to the Claimant, W.S., all augmented benefits (for his sole dependent, his wife) to which he is entitled under the Act, commencing March 1, 2002.

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DANIEL F. SOLOMON
Administrative Law Judge

Washington, D.C.

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).